DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/05/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A, BUILDING			(X3) DATE SURVEY COMPLETED	
		445512	B. WING			11/03/2020	
NAME OF PROVIDER OR SUPPLIER NASHVILLE CENTER FOR REHABILITATION AND HEALING LL				STREET ADDRESS, CITY, STAT 832 WEDGEWOOD AVENUE NASHVILLE, TN 37203			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFII TAG	(EACH CORRECTIVE CROSS-REFERENCED	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)		
F 000	#TN00051893, #TN a COVID-19 Focus 11/3/2020 at Nashv and Healing. No de the complaint inves #TN00051893, #TN The facility was fou CFR §483.80 infect has implemented the Medicaid Services (1985).	ations #TN00051877, N00052070, #TN00052418 and ed Survey were completed on ille Center for Rehabilitation ficiencies were cited related to tigations #TN00051877, N00052070, #TN00052418. Ind to be in compliance with 42 tion control regulations and the Centers for Medicare and (CMS) and Centers for d Prevention (CDC) ctices to prepare for	FO)00			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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		445512	B. WING	<u> </u>	11/	03/2020	
į.	PROVIDER OR SUPPLIER	HABILITATION AND HEALING LL		STREET ADDRESS, CITY, STATE, ZIP CODE 832 WEDGEWOOD AVENUE NASHVILLE, TN 37203			
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E 000	Survey was conduction 11/3/2020 at Nas Rehabilitation and H	sed Emergency Preparedness sted by the State Agency (SA) shville Center for Healing. The facility was found with 42 CFR §483.73 related	EO				

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PRINTED: 11/05/2020 FORM APPROVED Division of Health Care Facilities (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING: B. WING 11/03/2020 TN1938 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 832 WEDGEWOOD AVENUE NASHVILLE CENTER FOR REHABILITATION A NASHVILLE, TN 37203 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5)(X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX PREFIX** CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) N 000 N 000 Initial Comments Complaint investigations #TN00051877, #TN00051893, #TN00052070, #TN00052418 and a COVID-19 Focused Survey were conducted by the State Agency (SA) on 11/3/2020 at Nashville Center for Rehabilitation and Healing. No deficiencies were cited related to the complaint investigations #TN00051877, #TN00051893, #TN00052070, #TN00052418. The facility was found to be in compliance with infection control regulations and has implemented the Centers for Medicare and Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19 under Chapter 1200-8-6, Standards for Nursing Homes. Total census: 97.

Division of Health Care Facilities LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE